Gaudenzia at Park Heights
Gaudenzia Program for Substance Abuse and HIV/AIDS Services
Baltimore, Maryland
TI14539

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21702

PROJECT DESCRIPTION

Expansion or Enhancement Grant—Expansion and Enhancement

Program Area Affiliation—Reducing Disparities

Congressional District and Congressperson—Maryland 7; Elijah E.Cummings

Public Health Region—III

Purpose, Goals, and Objectives—The purpose of the proposed project is to ensure that the target population receives timely access to quality comprehensive treatment, prevention, aftercare, and support services. The overall project goal is to reduce the number of addicted high-risk and symptomatic HIV/AIDS individuals in the greater Baltimore area. More specifically, the program will aim to increase service utilization rates, retention of clients in treatment, and treatment completion rates. (pages 8, 13)

Target Population—The target population for the proposed project is substance-abusing African Americans, Hispanics/Latinos, and other minorities who are at high risk for HIV/AIDS or who have HIV/AIDS, including pregnant women; women and their children; men who inject drugs, including men who have sex with men (MSM) and at-risk non-injecting MSM; and individuals who have been released from prison/jail within the past 2 years. (page 7)

Geographic Service Area—The geographic service area is not clearly stated. In discussing the purpose of the project, the application refers to the "greater Baltimore area." (pages 6–8)

Drugs Addressed—Although there is no focus on any one particular drug, the project anticipates that its target population will closely profile the clients enrolled in the "People With Hope" (PWH) project, a similar TC program operated by the grantee but located in Philadelphia. The most commonly used substance will be cocaine/crack, followed by (in order of preference) cannabis, alcohol to intoxication, and heroin. (page 8)

Theoretical Model—The proposed project consists of two treatment modalities—a therapeutic community (TC) and an outpatient/intensive outpatient program. The TC is modeled on the PWH program, which is based on a unified, recovery-oriented, whole-person approach that integrates HIV/AIDS, substance abuse (SA), and psychological interventions. This perspective focuses on the duality of HIV/AIDS-related concerns accompanied by a SA disorder. The structure of the program is similar to that of the traditional TC—the daily regimen is highly structured and active, within a treatment environment that operates 24 hours a day, 7 days a week. The treatment process is defined in terms of program stages that reflect a developmental view of change. The program stages promote a gradual, incremental transformative process that is based on increasing degrees of responsibility. This perspective emphasizes that recovery is a continuing process with identifiable stages and that the goals of each setting, intervention, or component are defined by the individual client's stage of recovery. The application does not elaborate on the outpatient/intensive outpatient program as a treatment model. (pages 10–11)

Type of Applicant—Not-for-profit (SF-424, item #7)

SERVICE PROVIDER STRUCTURE

Service Organizational Structure—The proposed project is the result of a grant from the City of Baltimore Substance Abuse Systems (BSAS), the agency that oversees the administration of substance abuse programs in Baltimore. Gaudenzia, Inc. is a not-for-profit organization founded in Philadelphia in 1968 with the explicit mission of providing quality treatment to individuals with SA and mental health (MH) disorders, including special programs for individuals with HIV/AIDS and persons with co-occurring SA and MH disorders. Gaudenzia operates 67 treatment programs, including 27 residential TC programs, and primarily serves indigent SA and MH clients. The Gaudenzia board of directors is the governing authority and is composed of 18 individuals who direct the organization's 67 programs. (pages 9, 24, 29)

Service Providers—The grantee will contract with the National Development and Research Institutes, Inc. (NDRI) to evaluate the project, as well as to provide training and technical assistance in the delivery of HIV/AIDS activities; and with Park West Medical Center (PWMC) to provide community outreach, on-site HIV/AIDS education and resource services, and counseling services to residential clients. NDRI was established in 1967 as a tax-exempt, not-for-profit organization that conducts research and provides technical assistance, training, outreach, prevention, and other SA-related activities. In 2000, NDRI created a division called the Center for the Integration of Research and Practice (CIRP), whose mission is to integrate science with services and to advance the research-for-practice efforts of NDRI. PWMC is a respected primary medical care facility in Park Heights. It provides quality medical care for clients with HIV/AIDS, including mental health services. In addition to these contractual services, the project will also collaborate with the Park Heights Community Health Alliance, Inc. (PHCHA), a coalition of neighborhood associations, churches, schools, social service agencies, health care providers, and public officials. Specifically, Gaudenzia will be collaborating with the African American Health Alert (AAHA), an HIV/AIDS task force, whose street-based outreach focuses on HIV/AIDS and STD prevention, as well as treatment referral. PHCHA's contribution to the proposed project will be to provide outreach to the target population, on-site educational and counseling sessions to residential clients, and assistance with aftercare planning and support in the community. (pages 24–25)

Services Provided—The proposed project replicates Gaudenzia's highly successful modified TC program, PWH (described above). The program is based on four types of interventions: (1) community enhancement, (2) therapeutic/educational, (3) community and clinical management, and (4) vocational. Rooted in these interventions, the primary program activities include the following:

- Morning meetings—to establish community affiliation for building a supportive community
- Encounter groups—to achieve a basic foundation of abstinence upon which the other program elements are built
- Peer-work hierarchy—to increase personal responsibility and begin the process of vocational training

As previously mentioned, the basic program structure is similar to that of traditional TCs, with some modifications. The proposed program is designed to be more individualized, more flexible, and less intense, placing a greater emphasis on instruction and education and on understanding HIV/AIDS, SA, and associated MH disorders, as appropriate. Also inherent in this design is a greater emphasis on health and medical matters. Collaboration with community-based

HIV/AIDS service providers is frequent, with clients receiving many specialized and social services through multiple agencies located outside the facility. To ensure continuity with the client's treatment plan, these agencies provide client care through assigned case managers whose services will be coordinated by the counselor at the proposed project. For individuals with co-occurring MH disorders, the proposed TC provides psychiatric evaluation and psychotropic medication to stabilize the client's psychiatric symptoms and facilitate program participation. Recovery groups address the inter-relationship of the client's SA and psychiatric problems. Finally, because most relapses occur within the first 6 months of the transition into the community, intensive HIV/AIDS intervention services will be initiated while the client is still at the TC. To effect a smooth transition into the community during this crucial transition period, the proposed program will initiate "Integrated Aftercare Services" during the client's re-entry phase of treatment.

When clients prepare to leave the TC, an aftercare program is developed. This plan refers clients to the Gaudenzia outpatient and other programs for continued counseling, medical treatment for HIV/AIDS, and educational/vocational rehabilitation, all coordinated with outside agency case managers through the Gaudenzia aftercare counselor. Other clients will enter the proposed outpatient program through outside sources, having been identified as needing outpatient treatment as primary care or as aftercare from another program. The application does not provide a description of the outpatient program/services. (pages 10–11)

Service Setting—The proposed project will be located in the Park Heights section of Baltimore, which has a high rate of HIV/AIDS, syphilis, and gonorrhea. The proposed program will be housed in a building that is in close proximity to social and health services, educational and vocational organizations, and employment opportunities. Several 12-Step meetings are also within walking distance. The location is easily accessible by bus and other modes of public transportation. However, if needed, the project will maintain a vehicle to provide transportation for clients to be admitted or for scheduled appointments. (pages 9, 28–29)

Number of Persons Served—The proposed project will provide services to approximately 345 individuals (unduplicated) from the target population over the 5-year grant period as follows:

- 172 clients served by adding 10 new TC program beds (6 male and 4 female) exclusively for persons with symptomatic HIV/AIDS
- 173 clients served by providing expanded outpatient/intensive outpatient services for primary care and up to 2 years of aftercare

(pages 2, 8–9, 13, 19)

Note: The numbers above were used because they are repeated in several sections of the application, including the project abstract (page 2), indicating that 345 (unduplicated) clients is the true number to be served. However, the project narrative is not clear with regard to the 345 total, and the information presented elsewhere in the narrative, particularly (1) the connection between the unduplicated client counts and totals presented on page 13 and those provided on pages 18–19) and (2) the connection between the numbers shown in Table 2 and the total of "517 unduplicated individuals," both shown/stated on page 13—i.e., 103 clients per year for 5 years is close to the total of 517 (i.e., 515), which might be explained as a typographical error. However, these calculations are further confounded by the project's later statement that it will not accept/ collect baseline data on any new program admissions after the 7th month of Year 4 (i.e., less than 4 years of baseline data collection) (pages 18–19).

Desired Project Outputs—The application lists several desired project outputs, categorizing them as follows:

Treatment outcomes:

- Reduced substance use
- Reduced criminal justice system involvement
- Increased acquisition of stable housing; employment; and GED completion
- Increased adherence to prescribed medication

HIV/AIDS services:

- Increased adherence to prescribed HIV services/medication
- Decreased occurrence of opportunistic infections
- Decreased engagement in HIV risk behaviors
- Improved CD-4 and viral load

The project also anticipates a decrease in crime and in health and social services costs to occur as a result of client stabilization in recovery, the upshot of which will also lead clients to become productive members of the community. In turn, it is hoped that the community at large will have a more positive attitude regarding the target population and its potential for recovery. (pages 9, 21)

Consumer Involvement—The project states that it is very committed to consumer involvement and that consumers are an integral part of the development, refinement, and improvement of the proposed program. During the formative stages of this proposal, clients and staff in the Philadelphia-based PWH program and the current Gaudenzia programs in Baltimore provided input on the critical needs for future program development. A focus group of high-risk clients was also conducted to gather input on the needs of individuals with HIV/AIDS. A diverse volunteer project advisory board, the majority of which is composed of consumers, participated in key informant interviews to aid in identifying areas for program improvement and unmet client needs. This board will provide ongoing assistance and advice on program implementation and activities, including participation in the evaluation. (pages 11, 14–15, 23)

EVALUATION

Strategy and Design—The proposed evaluation plan includes process and outcome components. It employs a prospective, longitudinal, repeated measures design and analytic plan to evaluate client change over time, correlations between client characteristics and treatment outcomes, comparisons between clients who successfully complete the program versus those who do not (non-completers), and the success of program implementation. The statistical analyses conducted will be paired-samples t-tests, independent-samples t-tests, chi-square tests, and difference of proportion tests. (pages 18–19)

Evaluation Goals/Desired Results—The overall desired result for the project evaluation is that the analysis provides supportive documentation of the effectiveness of modified treatment interventions and that the analysis results are informative to current treatment practices, so that the design and delivery of services to the target population are improved. The goal of the process evaluation is to assess the degree to which intervention has been delivered, the fidelity between

the intervention as designed and as implemented, and the degree to which the intervention reaches the target population. The outcome evaluation, on the other hand, is designed to assess the relationship between treatment and client improvement across a range of outcome variables (listed below). (pages 18–20)

Evaluation Questions and Variables—The application states one general evaluation question that covers all elements of the outcome evaluation: Do clients who receive the program demonstrate significant improvement [as a result of treatment]? Although not stated, it can be inferred from the process evaluation goals (stated above) that the general process evaluation question is, Was the program delivered as intended? Primary outcome variables include client demographics; length of stay; referral source; substance use and history, including treatments; mental health status and history; family and social relationships; medical and physical health status, including HIV/AIDS status/engagement in high-risk activities such as injection drug use; employment status, income level, and educational background; living arrangements; entitlements; and criminal justice involvement/legal status. Primary process variables include number and type of target services provided, including number of staff–client contacts, number and characteristics of clients receiving services, and program admission and retention rates. (pages 13, 18, 20)

Instruments and Data Management—The proposed project will administer a battery of interview instruments and other data collection tools as follows:

- The Center for Substance Abuse Treatment (CSAT) Government Performance Reporting Act Core Client Outcomes Measure (GPRA)
- The CIRP/NDRI Baseline and Follow-up Interview—adapted from the Addiction Severity Index (ASI) and Risk Assessment Battery (RAB)
- Brief Symptom Inventory (BSI)
- Individual and group services utilization record (I/GSR)—used to track all target services delivered by staff to program participants
- Chart abstraction form
- Provider medical information form (using separate consents to obtain CD-4 and viral load information from medical providers)
- Gaudenzia program management information system (MIS)

Although it is clear that the GPRA data will be collected at baseline and at 6- and 12-month follow-up intervals, it is not clear if data collected via other instruments/sources will follow the same schedule. The project makes a general statement that the "battery [of assessment instruments] is administered at baseline, 6-months and 12-months post-baseline" (page 18), but it is not clear if "battery" refers to all instruments listed on page 19 or in Appendix 5, which does not directly correspond to the project narrative, or some combination.

An ACCESS database management system will be used to track clients and to schedule project interviews. Data entry will be completed by the research associate under the direction of the project evaluator, using cross-checks for logic/consistency, screening for atypical values, and a computerized program to clean/edit the data. Cleaned data will then be retained in an SPSS database. The local evaluation and GPRA data will be combined into one dataset for the analysis. (pages 18–19)